WOUND BASICS ASSESSMENT & MANAGEMENT

June 2016 Webinar Series

prepared for

State of Maryland

Developmental Disabilities Nursing Team

Presenters-

Baltimore Affiliate Wound Ostomy Continence Nursing Society

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Objectives Webinar Series 1- Assessment

1. Recognize principles of healthy skin care management

2. Identify 4 or more interventions which reduce the risk of pressure injury based on evidence based skin risk assessments

3. Discuss 4 or more components of a comprehensive skin/wound assessment.

4. Differentiate 3 or more interventions and associated wound characteristics that support wound healing.

5. Distinguish 3 or more characteristics of various wound etiologies including moisture associated skin injury, pressure injury, and venous, arterial, and neuropathic ulcers

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Objectives Webinar Series 2- Management

6. *Support wound dressing /treatment selections based on wound product categories associated with 3 or more patient centered assessment findings.*

7. *Appreciate principles of safe negative pressure wound therapy*

8. *Choose appropriate support surface application based on 2 or more unique patient centered needs*

9. *Identify community resources applicable to the chronic wound care management across care settings.*

Cost of wound care

- ✓ Absenteeism and loss of productivity
- ✓ Consumable products (eg, wound dressings)
- ✓ Care giver burden
- ✓ Medical devices (eg, castings, offloading devices, and so on)
- ✓ Government subsidies (eg, worker's compensation, welfare)
- ✓ Medications (eg, antibiotics, pain control)
- ✓ Insurance costs
- ✓ Labor (eg, nursing visits, physician time, ER time, allied professionals, and so on)
- ✓ Litigation costs

United States, chronic wounds affect an estimated 6.5 million patients. More than $25 billion is spent annually on the treatment of chronic wounds.

- ✓ Cost Hospital bed days (admissions and re-admissions, increased length of stay)
- ✓ OR time for procedures such as debridement, grafting, and so on Intangible
- ✓ De-conditioning
- ✓ Nutrition
- ✓ Loss of independence
- ✓ Rehabilitation
- ✓ Pain and suffering
- ✓ Quality of life impact

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Nursing process continues

- Comprehensive wound assessments allow for management by etiology and wound characteristics
- Drives the plan of care
    - Optimize the host
    - Address modifiable factors
    - Wound bed preparation
    - Product selection
    - Intraprofessional involvement

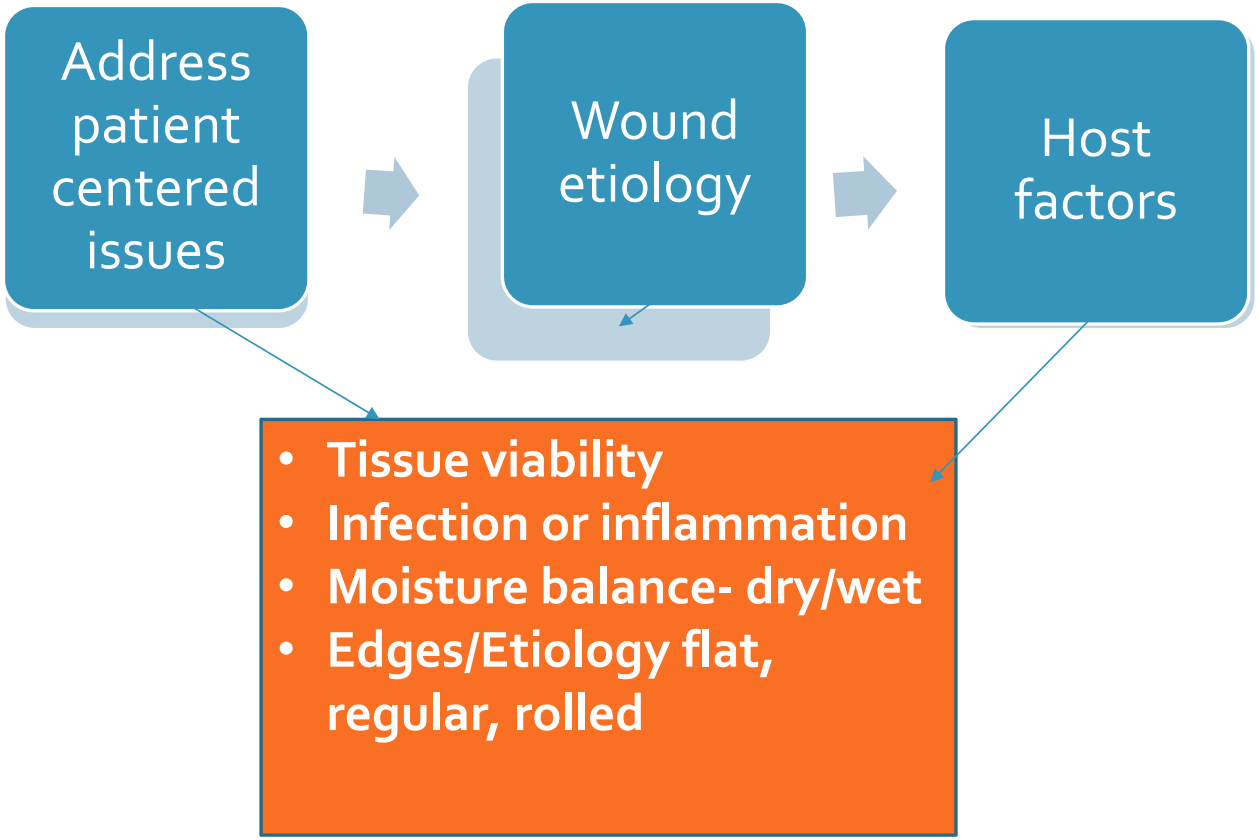
Optimize the host

- Treat infections
- Optimize glucose
- Disease state management
- Oxygenation and perfusion
- Pharmacologic review
- Pain management
- Incontinence management

Manage modifiable factors

- Take pressure off
- Nutrition – protein/calories/mvi
- Moisturize
- Mobility
- Incontinence management
- Smoking cessation
- Psychological support

Wound bed Preparation



The 6 Most Common Questions About Wound Care

#1 Shouldn't I leave my wound open to the air so it can breathe?

NO. Wounds heal much faster when they are left moist and covered

#2 What should I use to clean my wound?

Usually plain tap water is fine to clean your wound.
If you live in an area where the tap water is not drinkable, you should use cool previously boiled water.

#3 Do I need to clean the wound with hydrogen peroxide?

No, this can actually damage healing clean wounds

#4 Do I need antibiotic creams on the wound?

Not unless recommended by a health care provider. Many develop sensitivities to OTC antibiotic ointments

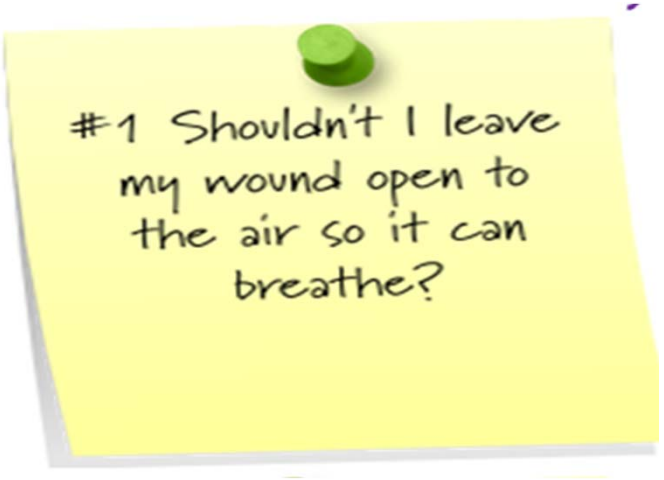
#5 What type of dressings should I use to cover the wound?

#6 When should I see the doctor about my wound?

Redness, warmth, pain, drainage, odor, discoloration and wounds that don't heal or improve

SkinCare Physicians

http://www.skincarephysicians.net/skin-care/everything-you-need-to-know-about-wound-care-in-six-questions-2/



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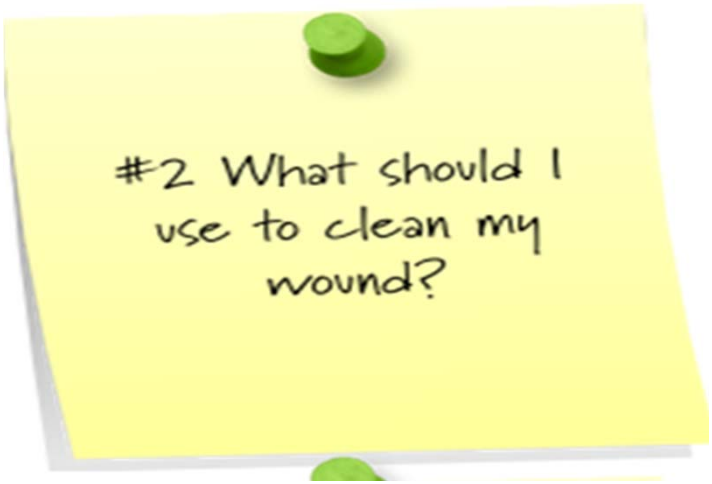

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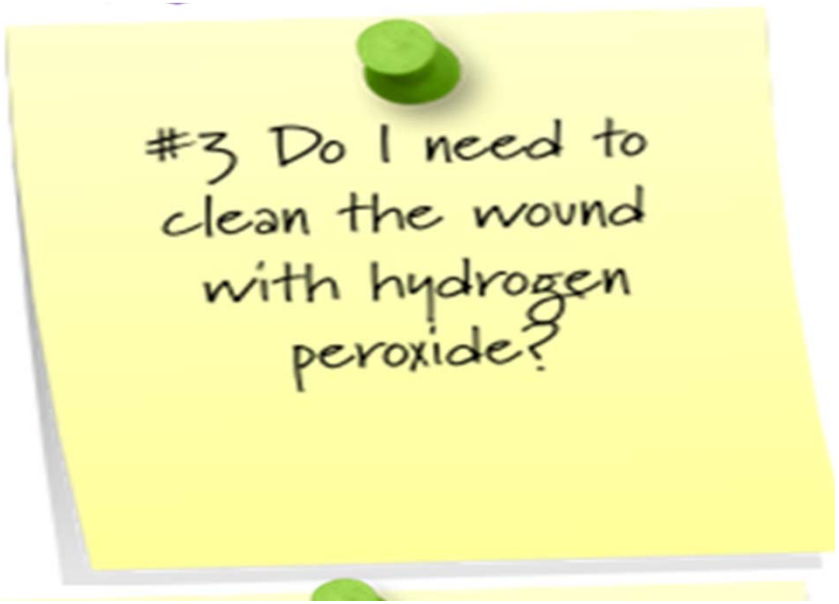

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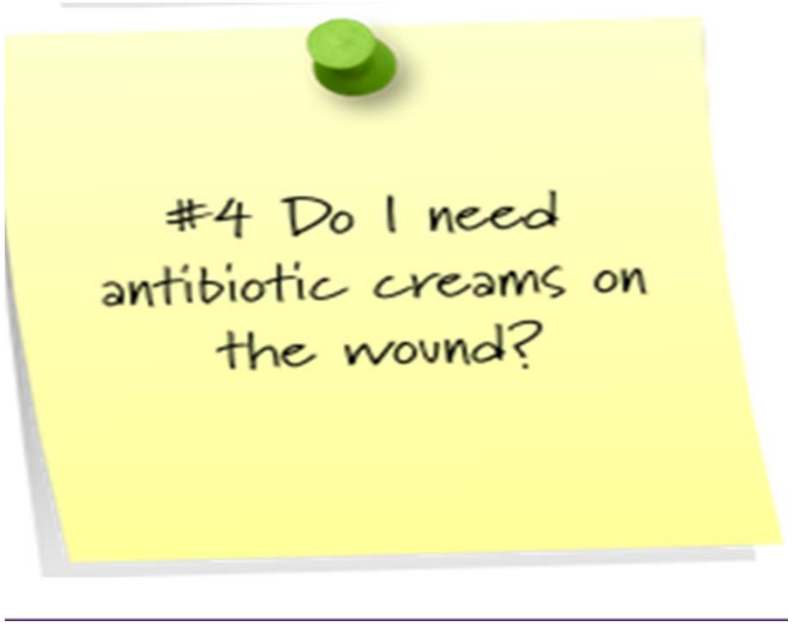

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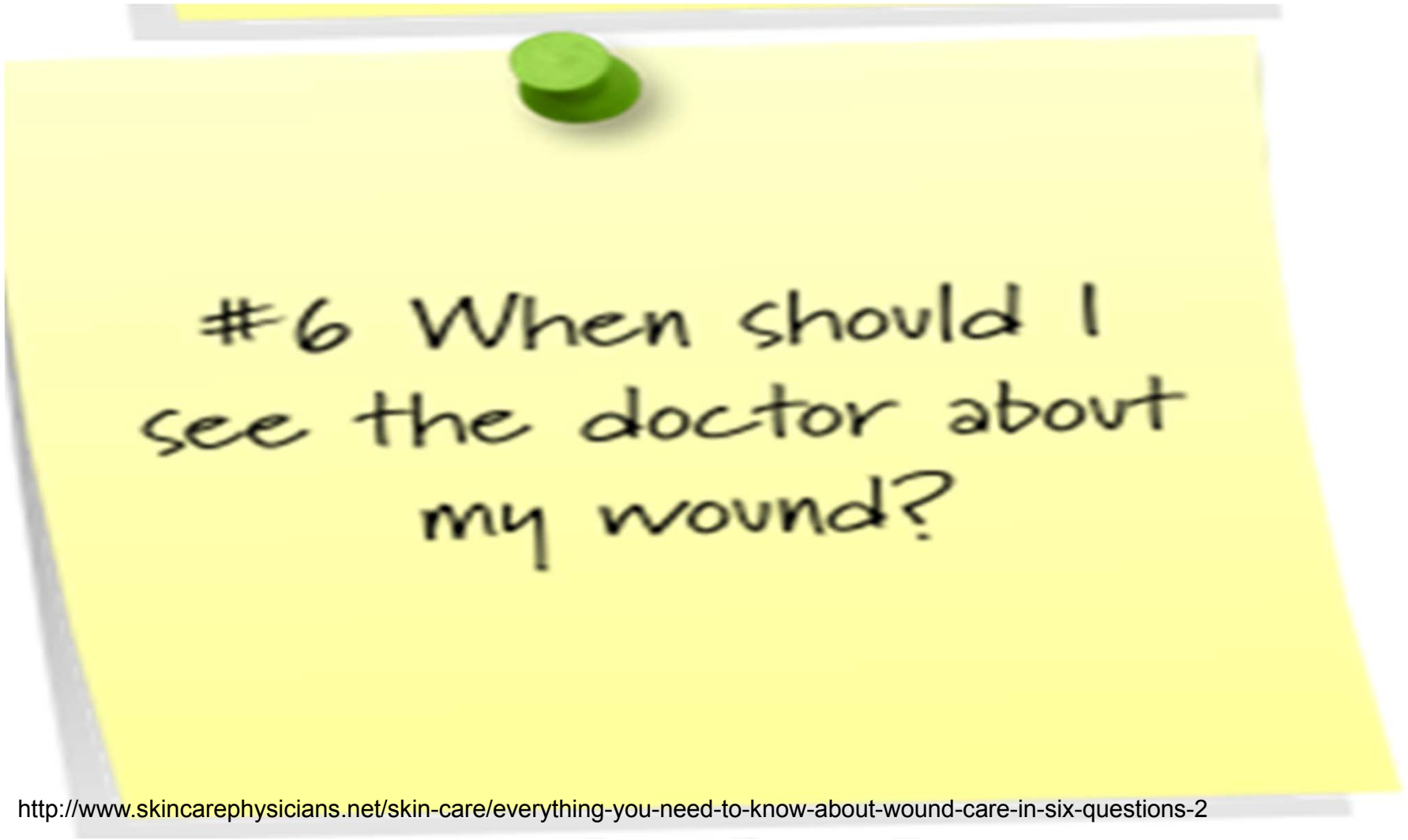

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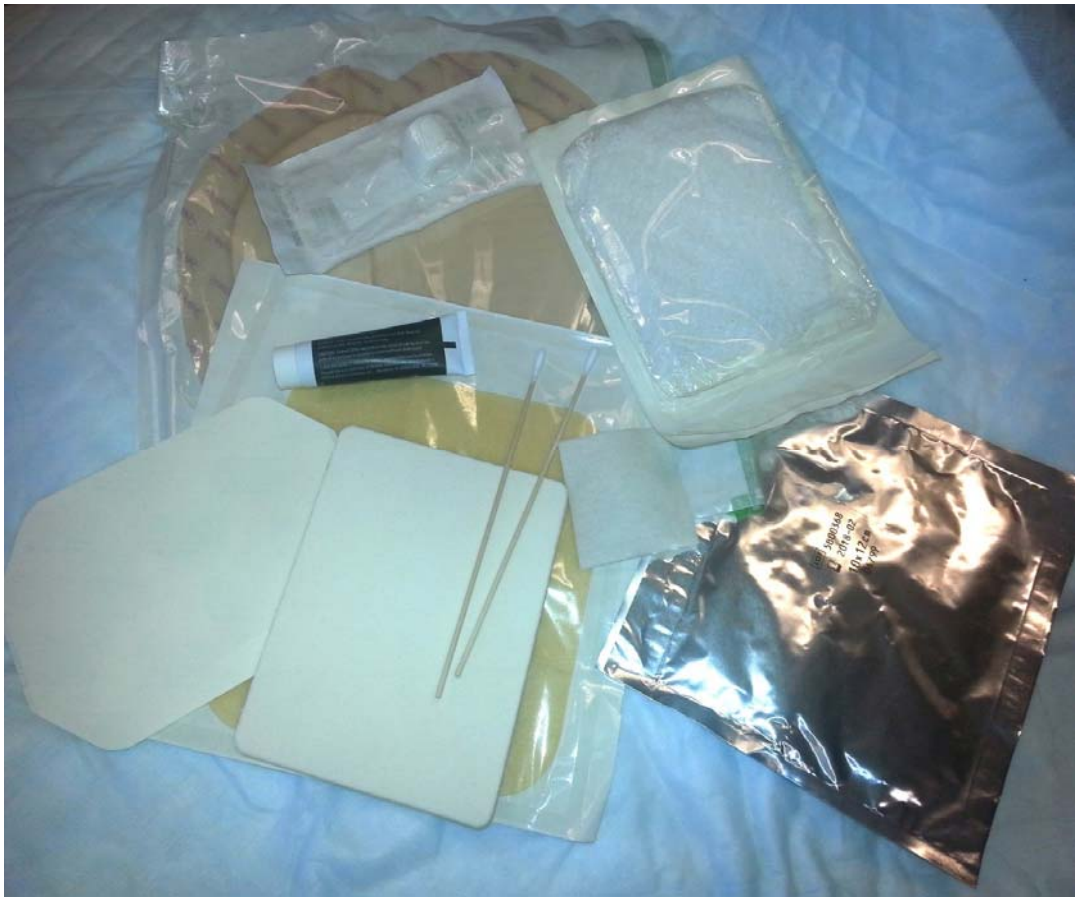
#5 What type of dressings should I use to cover the wound?



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Wound Dressing Categories

- Absorptives
- Alginates
- Antimicrobial Dressings
- Biologicals & Biosynthetics
- Collagens
- Composites
- Alginates
- Antimicrobial Dressings
- Biologicals & Biosynthetics
- Collagens
- Composites
- Contact Layers
- Elastic Bandages
- Foams
- Gauzes & Non-Wovens
- Honey (Active Leptospermum)
- Hydrocolloids
- Hydrogels: Amorphous
- Hydrogels: Impregnated
- Hydrogels: Sheets
- Impregnated Dressings
- Silicone Gel Sheets
- Solutions
- Transparent Films
- Wound Fillers

The dressing is just the side dish

Goals of wound care

Healable

Maintenance

Non-healing

Palliative

T issue (viable/nonviable)

- Debridement- mechanical, chemical, autolytic

I nfection/inflammation

- Wound cleansing
- Antiseptics
- Antimicrobial dressings
- Infection control

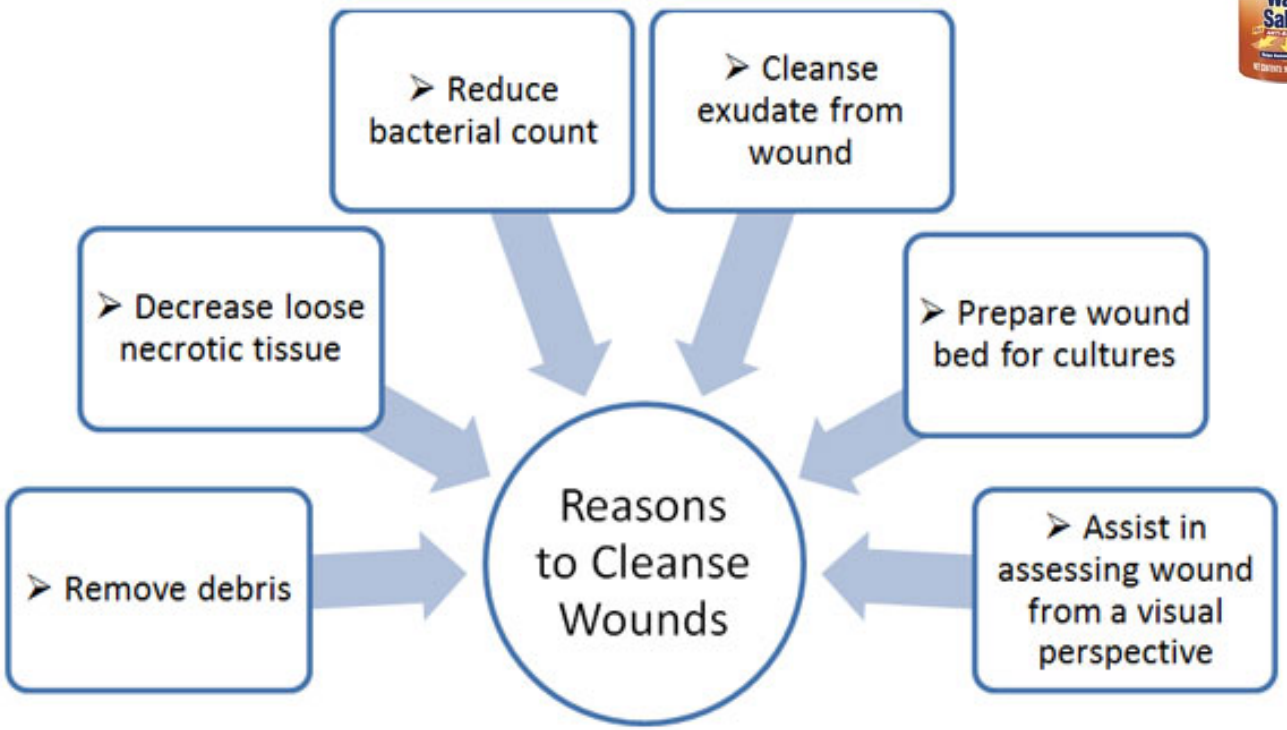
M oisture balance

- Manage exudate/absorption-contain
- Prevent desiccation

E dge /Etiology

- Fill Undermining/dead space

Wound cleansing



Wound Management Principles (TIME)

Tissue

- Deficits
- Presence of necrotic tissue

Infection/Inflammation

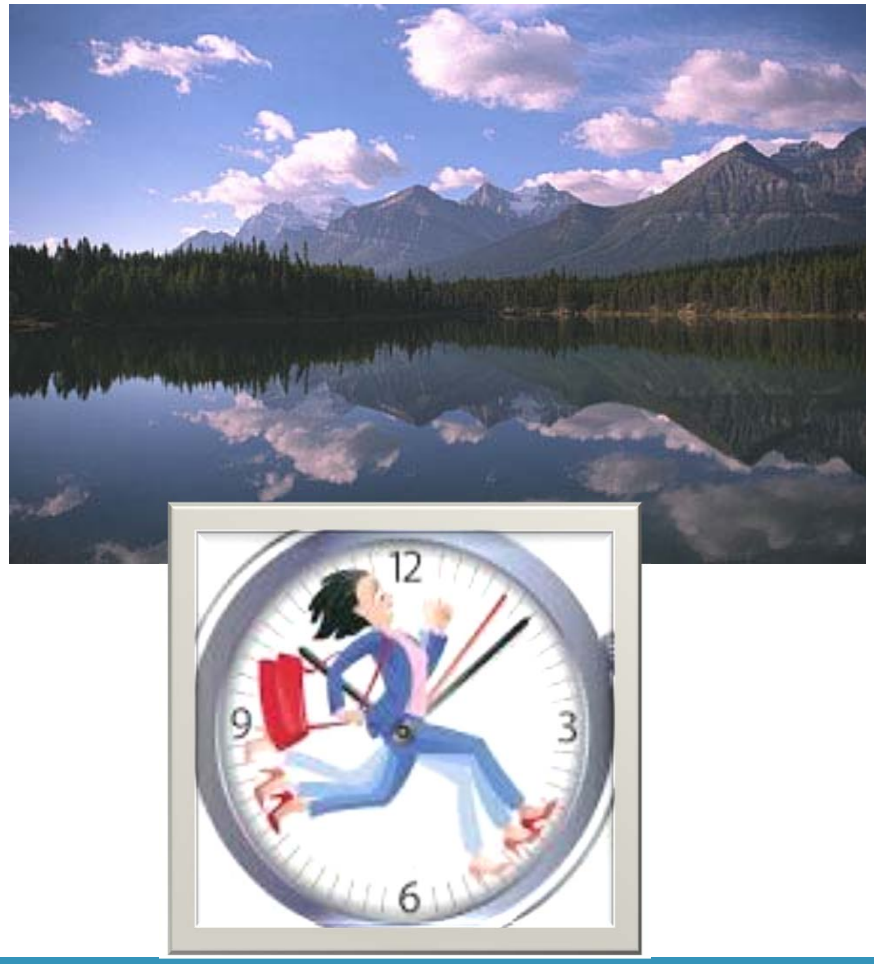
- Address bioburden and inflammation

Moisture Balance

- Maceration to desiccation

Edge/Etiology

- Quality of the wound edge
- Specific needs per wound etiology



T issue (viable/nonviable)

Debridement-

mechanical

chemical

autolytic

biological

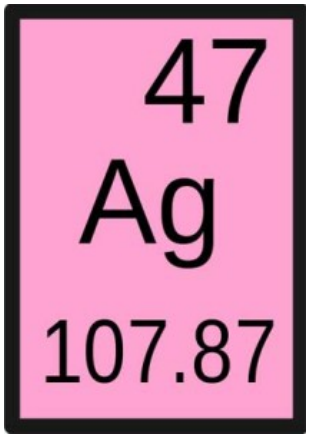
Protect/Insulate

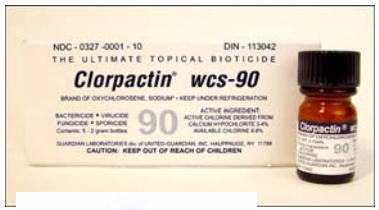
Enzymatic Debriding Agent

- Needs moisture to work
- Liquefies nonviable tissue/slough
- Protect periwound skin
- Do not combine with silver or other antimicrobials

T issue (viable/nonviable

Infection/inflammation

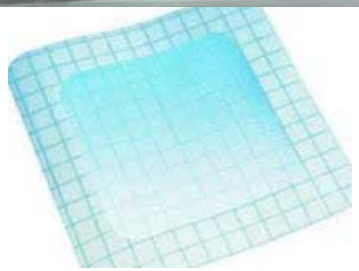




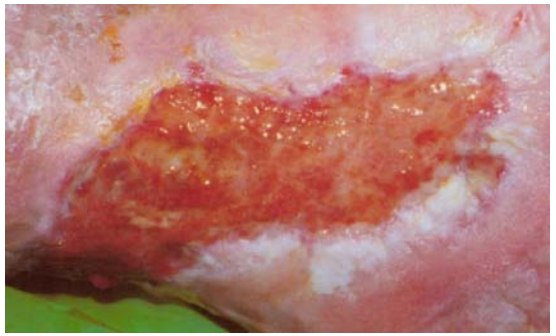
- Wound cleansing
- Antiseptics
- Antimicrobial dressings
- Infection control

- For short term use – limit 5-7 days

M oisture balance (add or absorb)



- Manage exudate/absorption-contain
- Prevent desiccation



E dge /Etiology

- Fill Undermining
- Fill dead space

Transparent films

Do not absorb
Provide moisture
Minimal debridement via autolysis
Adhesive may be aggressive
Caution when removing.

Hydrocolloids

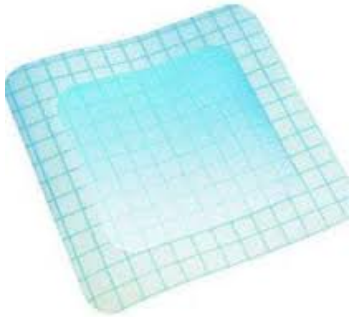
- Moderately absorbent
- Can assist in autolytic debridement
- Impermeable to bacteria and other contaminants

- Tend to "melt out". Can macerate wound edges

May have odor and be confused with purulent drainage

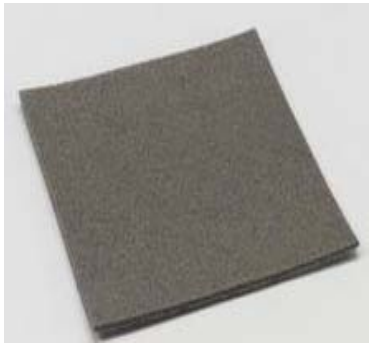
Hydrogels

- Minimally absorbent - Maintains hydration by donating
- Moisture to dry wound
- Uniquely cooling and soothing (useful for burns)
- Can promote autolytic debridement
- Can macerate wound edges (use skin barrier film like No-sting)
- May dehydrate easily of not covered



Foams/Silicones

- Highly absorbent
- Removes drainage from wound surface
- Provides cushioning
- Generally non-adherent



Alginates/Hydrofibers

- Highly absorbent (up to 20-30 times their weight)
- Fast rate of absorbency
- Fills in dead space

- Can dry out a wound that is not draining enough
- Can dry out without appropriate secondary dressing
- May leave fibers in wound bed

Wet to Dry (Gauze soaked with saline)

- Can conform to deep wounds
- Inexpensive in short term
- Not impermeable to bacteria (can crawl through 64 layers of dry gauze!)
- Delays healing by cooling wounds
- Need frequent changing, at least BID
- Increased pain with dressing changes
- Removes healthy and unhealthy tissue when allowed to dry (non-selective debridement)
- Can macerate wound edges
- Labor/time intensive

Let's hang those wet to dry dressings out to dry!

Basic guidance for wound product selection

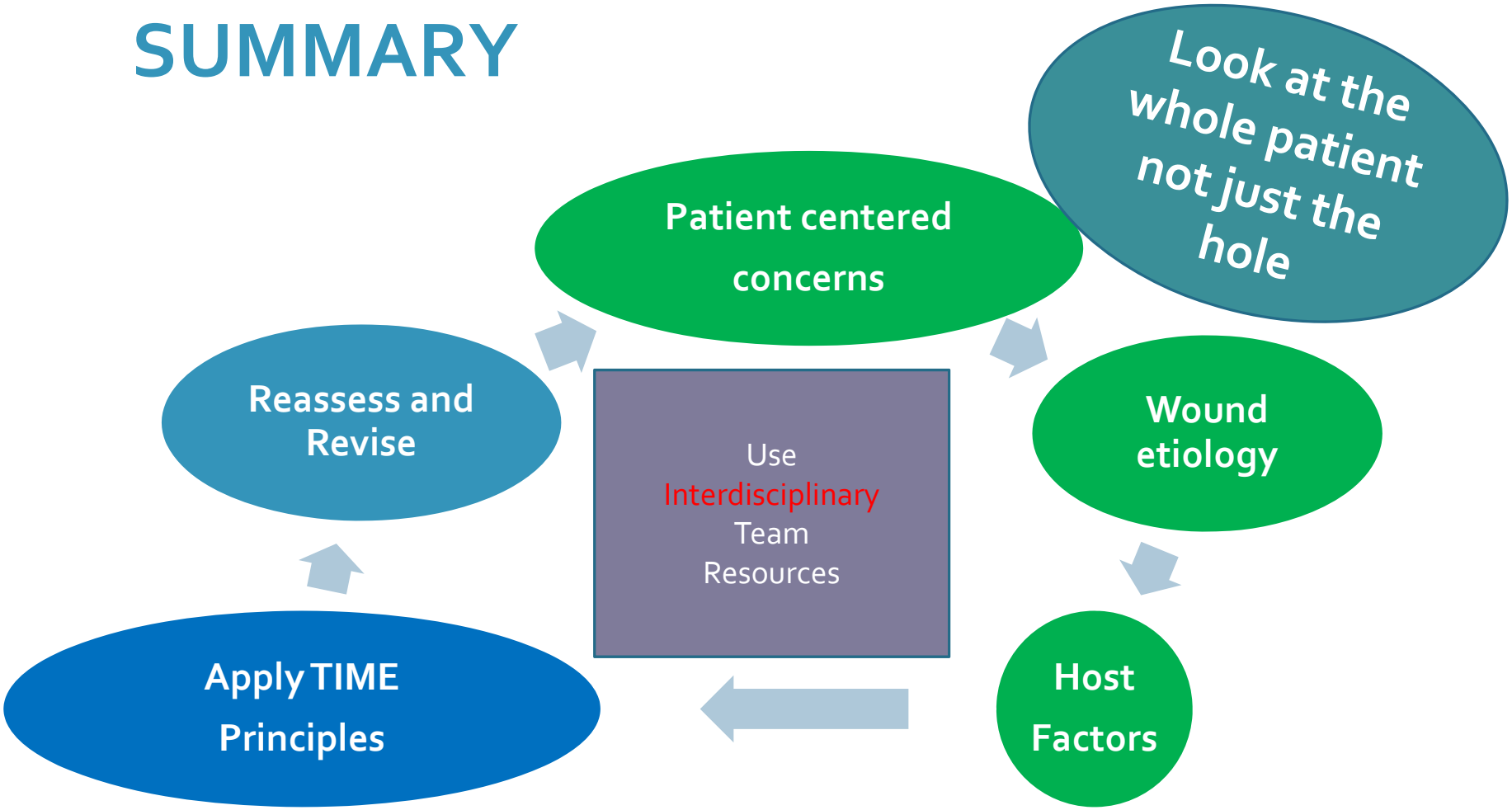
Dry wound	Minimal exudate	Moderate exudate	Heavy exudate
Non adherent island dressing	Hydrogel	Calcium alginate	Hydrofiber
Hydrocolloid	Hydrocolloid	Hydrofiber	Foam
Films semi permeable	Silicone absorbent	Foams	Absorbent dressing
		Negative Pressure	Negative pressure wound therapy
			Ostomy pouching

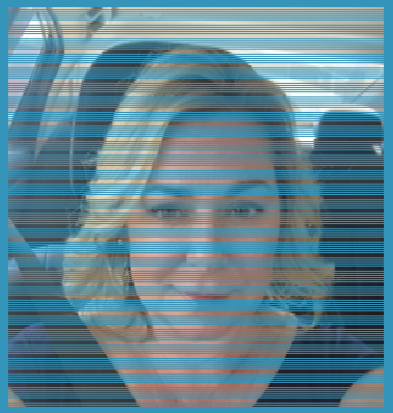
If depth is present, fill dead space and protect edges

Compression therapy

- Unna boot
- Multilayer compression wrap-
  (Profore, Comprilon, Dyna –flex)
- Reduces edema
- Tx venous ulcers/lymphedema

SUMMARY


Look at the whole patient not just the hole
Patient centered concerns
Wound etiology
Host Factors
Use Interdisciplinary Team Resources
Apply TIME Principles
Reassess and Revise



Joyce Onken, RN, BSN, CWOCN

QUESTIONS?

Support wound dressing /treatment selections based on wound product categories associated with 3 or more patient centered assessment findings.

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V.A.C.® THERAPY SAFETY INFORMATION

Disclosures:
-President Baltimore Wound Ostomy Continence Society AND
Employed by Acelity/KCI

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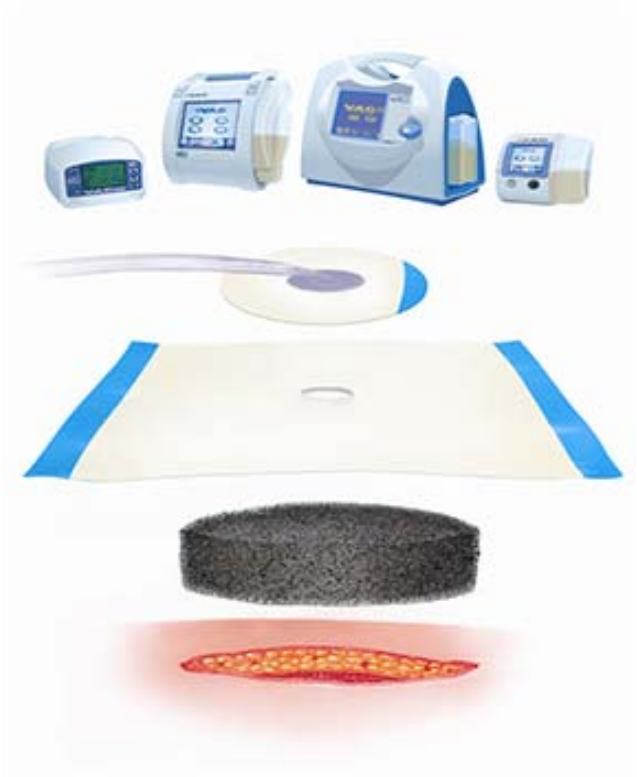
V.A.C.® Therapy Introduction

What is V.A.C.® Therapy?

- The V.A.C.® Therapy Systems, including the V.A.C.® GranuFoam™ Dressings, are integrated wound management systems intended to create an environment that promotes wound healing

What are the Components?

- The **V.A.C.® Therapy Unit** provides software-controlled negative pressure wound therapy
- The **V.A.C.® Canister** collects the wound exudate
- **SensaT.R.A.C.™ Technology** monitors and maintains pressure at the wound site to provide delivery of prescribed negative pressure settings
- **The V.A.C.® Drape** helps provide a moist wound healing environment
- **V.A.C.® GranuFoam™ Dressings** contract under negative pressure, providing direct and complete contact with the wound bed
  - The 400-600 micron reticulated pores help distribute pressure through the wound bed
  - Facilitate fluid removal



V.A.C.® Therapy
Safety Information

Important Safety Information

- In most cases, unless otherwise indicated, these slides will reference indications and safety information generally applicable to V.A.C.® Therapy.
- Before using V.A.C.® Therapy, read all safety information which is provided with the therapy unit, as well as in dressing and canister cartons.
- Certain unique indications, contraindications, warnings, and precautions apply for products within KCI Negative Pressure Therapy Systems, including the V.A.C.Ulta™ NPWT System, the V.A.C. Instill® Wound Therapy System, the ABThera™ Open Abdomen Negative Pressure Therapy System and the Prevena™ Incision Management System. Prior to use, read the instructions for use provided for the specific therapy unit or disposables for specific product information.
- Please refer to the V.A.C.® Therapy Clinical Guidelines, A Reference Source for Clinicians (available at www.kci1.com), for additional information when establishing patient-specific treatment protocols.
- Additional information and education on KCI Negative Pressure Therapy topics, including V.A.C.® Therapy, can be found on www.kci1.com. Clicking on the Education & Training link will provide information on these educational opportunities.
- V.A.C.® Therapy Systems are Rx only devices.

V.A.C.® Therapy is indicated for patients with:

- Chronic Wounds
- Acute Wounds
- Traumatic Wounds
- Sub-acute Wounds
- Partial-thickness burns
- Dehisced wounds
- Ulcers such as:
  - Diabetic
  - Venous Insufficiency
  - Pressure
- Flaps
- Grafts

V.A.C.® Therapy Contraindications

- DO NOT place any V.A.C.® Foam Dressings (V.A.C.® GranuFoam™, V.A.C. GranuFoam Silver ®, V.A.C.® WhiteFoam, V.A.C. VeraFlo™ and V.A.C. VeraFlo Cleanse™ Dressings) in direct contact with exposed blood vessels, anastomotic sites, organs or nerves.

- DO NOT use V.A.C.® Therapy:
  - when there is malignancy in the wound
  - with untreated osteomyelitis
  - with non-enteric and unexplored fistulas
  - with necrotic tissue with eschar present

- DO NOT use the V.A.C. GranuFoam Silver® Dressing on a patient with a known sensitivity to silver

V.A.C.® Therapy Warning Categories

Bleeding

- **To decrease bleeding risks:**
  - Protect vessels and organs
  - Infected vessels are at risk of complications and must be carefully noted and protected.
  - Cover or eliminate sharp edges
  - Ensure adequate wound hemostasis

- **Increase patient monitoring when:**
  - Anticoagulants, platelet aggregation inhibitors, aspirin, etc. are prescribed
  - Wounds are related to vascular surgical procedures
  - Infection is present in the wound

Considerations for V.A.C.® Therapy Patients at Increased Risk of Bleeding

- **With or without using V.A.C.® Therapy, certain wound care patients are at high risk of bleeding complications**
- **Place at-risk patient in a monitored setting as MD deems appropriate**
- **Are organs or vessels visible and/or exposed?**
  - Preferably cover with a thick layer of natural tissue
  - When natural tissue is not available, multiple layers of a non-adherent material can be used
  - Never place any V.A.C.® Dressing foam directly on organs, vessels, nerves, tendons, or ligaments
- **Are weak or friable vessels noted in or around the wound?**
  - Infection, trauma and radiation can weaken vessels, increasing rupture potential
- **Vascular surgery repairs** (i.e., vessels with sutures, anastomosis, graft, etc.)
  - Vessel repairs increase risk for complications regardless of treatment modality
  - Require close monitoring when wound close to large vessels (e.g., femoral , brachial)
- **Is adequate wound hemostasis present?**
  - Non-sutured hemostatic agents including spray sealants may dislodge under negative pressure foam dressing
  - DO NOT initiate V.A.C.® Therapy until bleeding is well controlled
- **Are medications or co-morbidities present that affect bleeding?**
  - Closely monitor patients on medications affecting bleeding times

► Clicking on the *Education & Training* link in www.kci1.com will give you access to the Vascular Surgical Wounds of Lower Extremity module.

V.A.C.® Therapy Warning Categories

Infection

- Infected wounds should be monitored closely and may require more frequent dressing changes than non-infected wounds.
- If there are any signs of the onset of systemic infection or advancing infection at the wound site, contact a physician immediately to determine if V.A.C.® Therapy should be continued.
- In the event of a clinical infection, V.A.C. GranuFoam Silver® is not intended to replace the use of systemic therapy or other infection treating regimens.
- V.A.C.® Therapy should NOT be initiated on a wound with untreated osteomyelitis.
- If the V.A.C.® Dressing is in place, but therapy is OFF for more than 2 consecutive hours, the patient's risk for infection may increase; either change V.A.C.® Dressing and reinitiate therapy, or apply alternative dressing.

Considerations for V.A.C.® Therapy
Patients at Increased Risk of Infection

- **With or without using V.A.C.® Therapy, certain wound care patients are at high risk for infection**
- **Infection-weakened vessels can rupture and result in significant blood loss**
  - Protect all organs and vessels from direct V.A.C.® Dressing contact
- **More frequent V.A.C.® Dressing changes may be required for any suspected infection in the wound**
- **Place at-risk patient in a monitored setting as MD deems appropriate**
- **Closely monitor patient for worsening condition**
- **V.A.C.® Therapy should be considered only as an adjunct in the management of wound infection**
  - Use appropriate anti-infective agents and/or any other appropriate interventions (e.g. debridement, HBO) to combat wound infection
- **V.A.C.® Therapy should be ON (active) for 22 hours out of 24 hours**
  - If V.A.C.® Dressing in place and therapy off for more than 2 hours, notify MD, remove V.A.C.® Dressing, clean wound and:
    - Replace with new V.A.C.® Dressing or
    - Replace with alternate dressing if unable to continue with V.A.C.® Therapy

V.A.C.® Therapy Warning Categories

Foam Dressings

- **Do not place foam dressings into blind or unexplored tunnels**
- **Help prevent foam dressing complications** by:
  - Documenting number and type of materials placed in the wound
  - Maintaining a 48-72 hour dressing change schedule (no less than 3x week unless on a skin or skin substitute graft)
  - Using a non-adherent layer between wound bed and foam
  - Using appropriate dressing in appropriate area of the wound, e.g, V.AC.® WhiteFoam Dressings only in tunnels

Considerations for V.A.C.® Therapy Patients at Increased Risk for Retained Foam

- **Foam left in the wound for greater than the recommended time period may:**
  - Foster ingrowth of tissue into the wound,
  - Create difficulty in removing foam, or
  - Lead to infection or other adverse events.
- **V.A.C.® Dressings are radiolucent; they are not detectable by X-ray or other radiological methods**
- **Document on the drape or the V.A.C.® foam quantity label or ruler (if provided) and in patient's medical chart**: :
  - Date, number and type of foam pieces placed in the wound
  - Always count the total number of pieces removed and ensure the same number of foam pieces was removed as was placed
- **Visualize the wound bed completely**
  - Patient positioning should be consistent for each V.A.C.® Dressing change
  - Move redundant tissue to allow wound bed visualization if needed
  - Careful inspection of the wound to ensure all foam is removed is essential
- **In the absence of infection, change V.A.C.® Dressings at least every 48-72 hours; no less than 3 times a week**
  - Rapid granulation formation in some wounds/patients may increase risk for foam adherence

V.A.C.® Therapy Warning Categories

Canister Size • Allergy • Resuscitation • Use in Altered Environment

- 1000 mL canister is not recommended for use on patients:
  - At high risk of bleeding or
  - Unable to tolerate a large loss of fluid volume
- V.A.C.® Therapy products are latex-free
- Patients with a known **allergy** to acrylic adhesives may react adversely to the V.A.C.® Drape
  - Seek medical attention if patient experiences a severe reaction
- The foam dressing, if in the thoracic area, may interfere with **defibrillation** efforts
  - Joules may need to be adjusted to compensate or the dressing may need to be removed

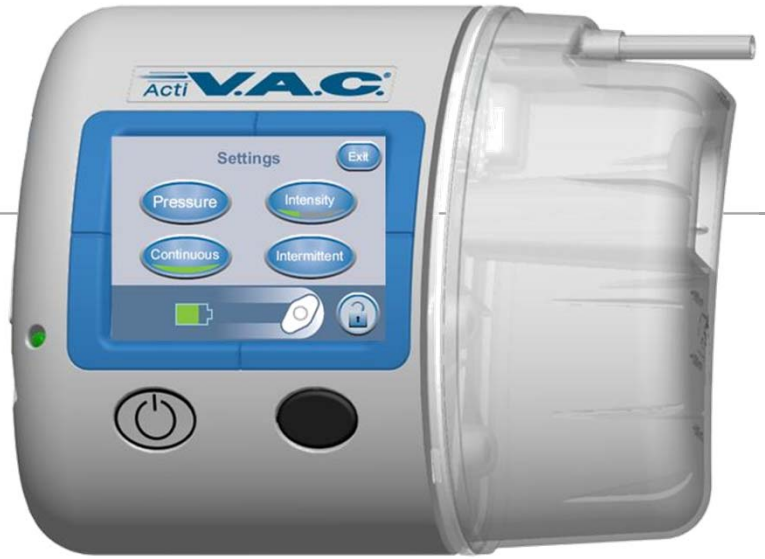
- V.A.C.® Therapy Units should not be taken into a Magnetic Resonance Imaging **(MRI)** environment as they are MRI unsafe
  - V.A.C.® Dressings, including V.A.C. GranuFoam Silver ® Dressings, may be used safely in the MRI suite
  - However, foam may interfere with quality of image
- V.A.C.® Therapy Units should not be taken into a Hyperbaric Oxygen Therapy **(HBO)** chamber as they are HBO unsafe
  - V.A.C.® GranuFoam™ and V.A.C.® WhiteFoam Dressings have been used safely in the HBO chamber
  - Ensure dressing tubing is not clamped during HBO therapy
  - The V.A.C.® GranuFoam™ Bridge Dressing contains additional synthetic materials which may pose a risk during HBO Therapy

V.A.C.® Therapy Precaution Categories

- **Standard precautions reduce the risk of transmission of blood borne pathogens**
- **Continuous therapy** setting is recommended for:
  - First 48 hours of V.A.C.® Therapy
  - Skin and skin substitute grafts
  - Highly exudating wounds
  - Tunnels and undermined areas
  - Difficult dressing applications
  - Painful wounds
- **Intermittent or Dynamic Pressure Control™*** should not be used in the situations recommended for continuous therapy
- **Patient Size and Weight** may influence response to fluid loss and dehydration
- **Spinal Cord Injury Patients may experience sudden changes in heart rate or blood pressure** due to autonomic dysreflexia, which requires removal from V.A.C.® Therapy
- **Bradycardia** may occur if foam dressing is placed close to the vagus nerve
- Wounds with enterocutaneous (entero-atmospheric) **fistula** require special dressing application techniques. Refer to V.A.C.® Therapy Clinical Guidelines.
- **Protect periwound skin** from foam contact
- **Circumferential dressings** should be applied loosely – do not tightly stretch drape as this may impair blood flow
  - Check circulation distal to dressing frequently
- **V.A.C.® Therapy Unit Pressure Excursions**
  - May occur if therapy unit senses blockage
  - Therapy unit may briefly go to -250mmHg or higher

* Dynamic Pressure Control ™ provided on V.A.C.Via™ and V.A.C.Ulta™ Therapy Systems.

ActiV.A.C.® Therapy Unit Buttonology

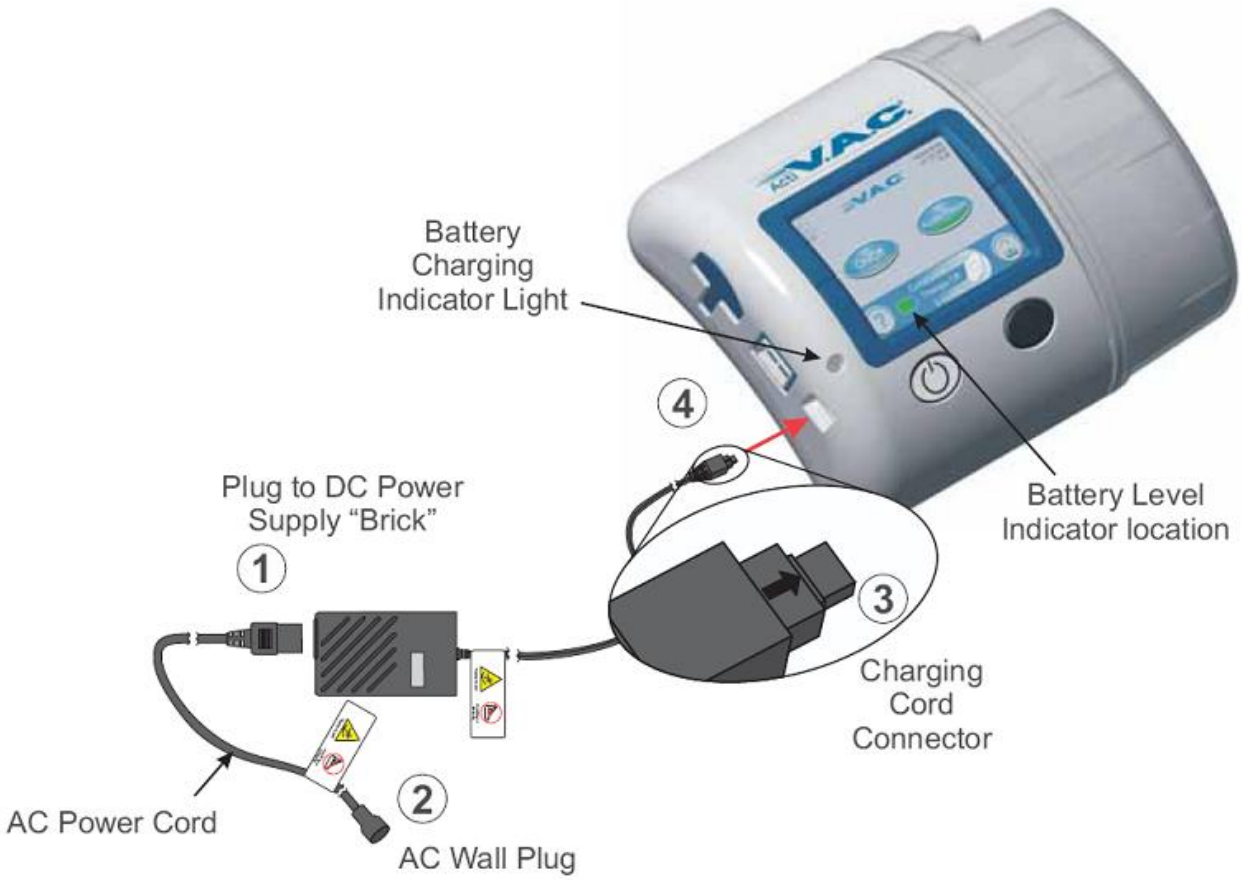


Prior to use of the V.A.C. Therapy System, it is important for the provider to consult treating physician and read and understand all Instructions for use, including Safety Information, Dressing Application Instructions and V.A.C. Therapy Clinical Guidelines.

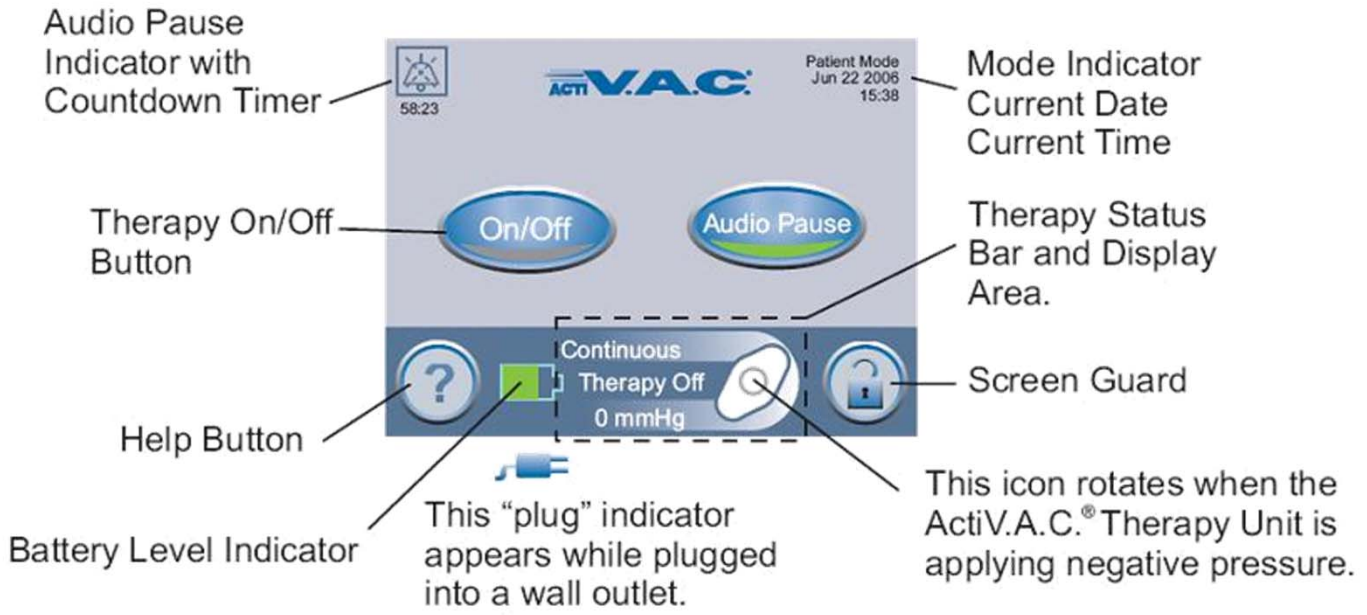
DSL #11-0496.US.

ActiV.A.C.® Therapy Unit

Battery Connection

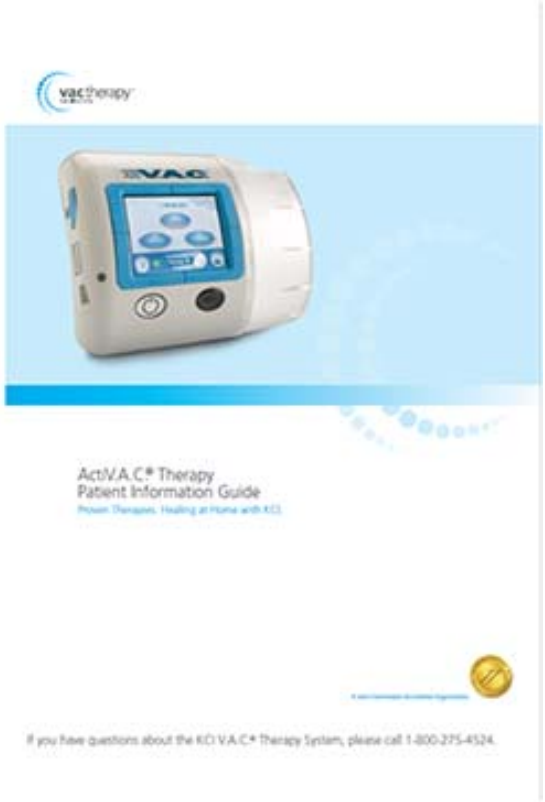


Patient Home Screen



Supporting Documents

ActiV.A.C.® Therapy
Patient Information Guide



ActiV.A.C.® Therapy System
Alarm Troubleshooting Guide

Carrying the Unit

4 different ways

Sue Grafton, RN, BSN, CWCN

QUESTIONS?

Appreciate principles of safe negative pressure wound therapy

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Support Surfaces - Objectives

- **The learner will –**
  - distinguish three main features of support surface technology
  - consider factors/forces that put skin at increased risk for compromise
  - identify three elements necessary for insurance approval of support surfaces in the home setting

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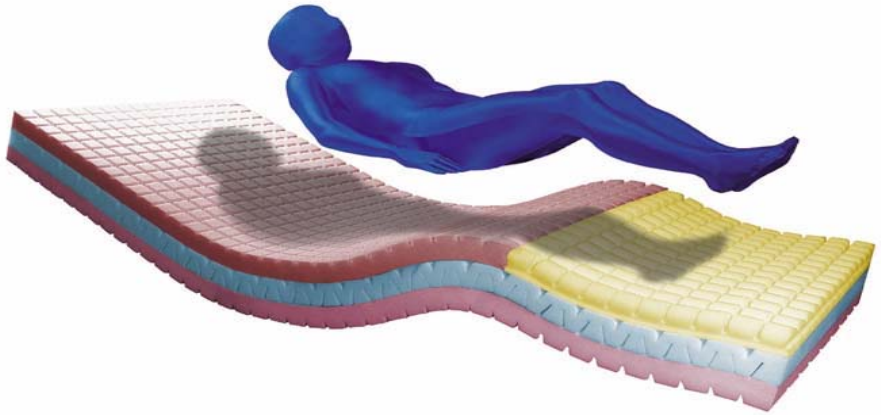
Before we get started…a word of warning…

- There are **NO** support surfaces on the market that take the place of good old-fashioned turning, repositioning or off-loading…

Definition: Support Surface

- A **specialized device** designed for the management of a variety of complicating factors which may include; pressure, shear , friction and/or microclimate (Beitz et al)



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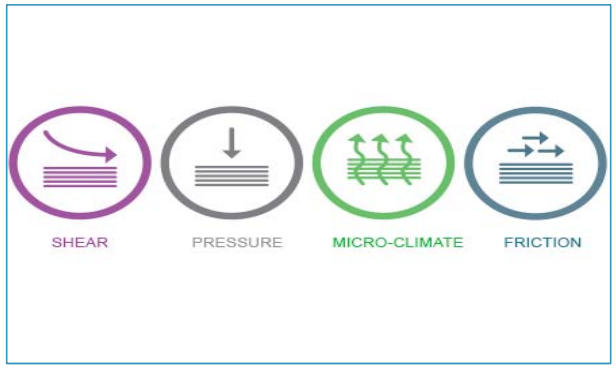
Skin Vulnerability ~ Factors and Forces

- **Shear -** a force that acts on an area of skin in a direction parallel to the body's surface; damage occurs BELOW skin level (Hess, 2004)
- **Pressure –** a force exerted on the body in a perpendicular direction; damage may occur ABOVE or BELOW skin level (Baharestani, et al 2010)
- **Friction -** a force exerted when skin is dragged across a coarse surface (such as bed linen); occurs ABOVE skin level (Hess, 2004)
- **Micro-climate –** skin temperature and moisture conditions (Baharestani, et al 2010)



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Not all specialty surfaces are created equal

- **Designs vary widely and may offer…**
  - Pressure redistribution
  - Moisture management

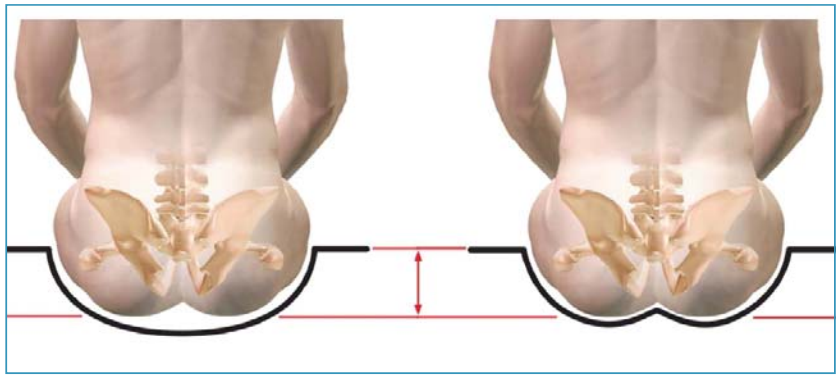
  - Some require special frames
  - Some "plug in" (powered); some do not
  - Some cover existing mattress (overlay); some replace existing mattresses
  - The list of variables goes on and on…

In a nutshell….a specialty surface is designed to….

Alleviate undue pressure or manage excess moisture (or both)

Pressure Redistribution

- Altering skin to surface contact areas reduces direct pressure forces
  - **Immersion** – depth of penetration (sinking in) into the support surface
  - **Envelopment** – support surface conform/mold to contours of the body



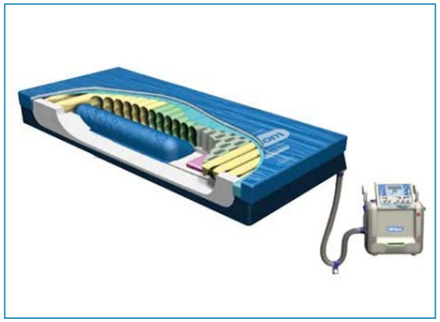
Immersion Envelopment

Specialized Surface Features

- **Air Fluidized** – pressure redistribution via a "fluid-like" medium created by forcing air through beads

- **Alternating Pressure** – pressure redistribution via cyclic changes

- **Low Air Loss** – air flow that manages microclimate



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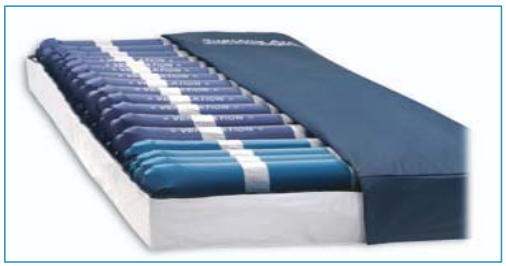
Pressure Redistribution features



- **Air –** flows through bladders and responds to movement

- **Foam** – porous polymer that conforms to weight

- **Gel** – semi-solid polymers that disperse weight

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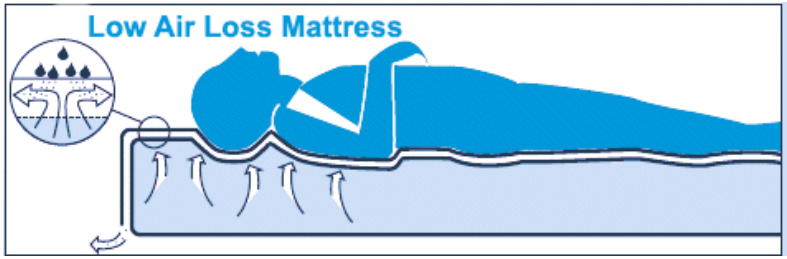
Moisture Management

- Skin that is too warm or too moist has less resilience, increasing the risk for skin compromise
- Low Air Loss surface – provides air flow through the mattress to manage heat and humidity



Air is forced through small holes in surface of mattress. This process wicks away any moisture and keeps patient dry, key in treating and preventing skin breakdown.

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Support Seating

- Seated support is just as important as supine support
- Cushion characteristics vary by design

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How to choose the correct surface…

- **It depends on the individual needs of the patient….**
- **Consider…**
  - Risk for skin compromise
  - Existing wounds/pressure ulcers
  - Moisture/incontinence issues
  - Mobility

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What does insurance cover?

- **It depends on…**
  - Type of insurance
  - Medical necessity
- **Must Have's –**
  - **Thorough documentation** supporting medical necessity
  - A **Physicians' order**
  - A competent and **savvy Social Worker** to navigate rules and regulations

Medicare Coverage: Support Surface Groupings

Group 1 – Non-powered overlay

- Completely immobile

Or

- Partial immobility or any stage PU

AND one of the following:

- - impaired nutrition
- - incontinence
- - altered sensory deprivation
- - compromised circulation

Group 2 – Powered mattress

- Stage 2 PU located on trunk/pelvis

AND has been on a Group 1 for greater than a month

AND has sores which have worsened or remained the same

OR

- Large or multiple Stage 3 or 4 PU

OR

- Has a myocuteneous flap or skin graft for PU

AND was on Group 2 prior

Group 3 – complete bed system

- Stage 3 or 4

AND is bedridden or chair bound

AND would be at risk for re-institutionalization if surface is not in use

Wheelchair Types

- Manual WC: self propels or pushed by someone else.
- Comes: standard, transport, bariatric.
- Specialty features:
  - Recliner: only backrest moves back.
  - Tilt and Space: seat and backrest pivot to redistribute pressure.

Tilt and Space

Wheelchair Types

Scooters:

Motorized devices with 3-4 wheels, swivel seat for easy transfer, discreet.

Power Wheelchairs:

Power base and seating component.

Support Surfaces – Key Concepts

- Support surfaces DO NOT take the place of routine turning, repositioning and/or off-loading.
- Support surfaces are used in coordination with an overall prevention and treatment plan
- Individual patient characteristics must be considered before selecting a surface
- **Donuts are not support surfaces and should not be used**
- Insurance plans often dictate eligibility

Sara Beth Rogers, RN, CWCN

QUESTIONS?

Choose appropriate support surface application based on 2 or more unique patient centered needs

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COMMUNITY RESOURCES

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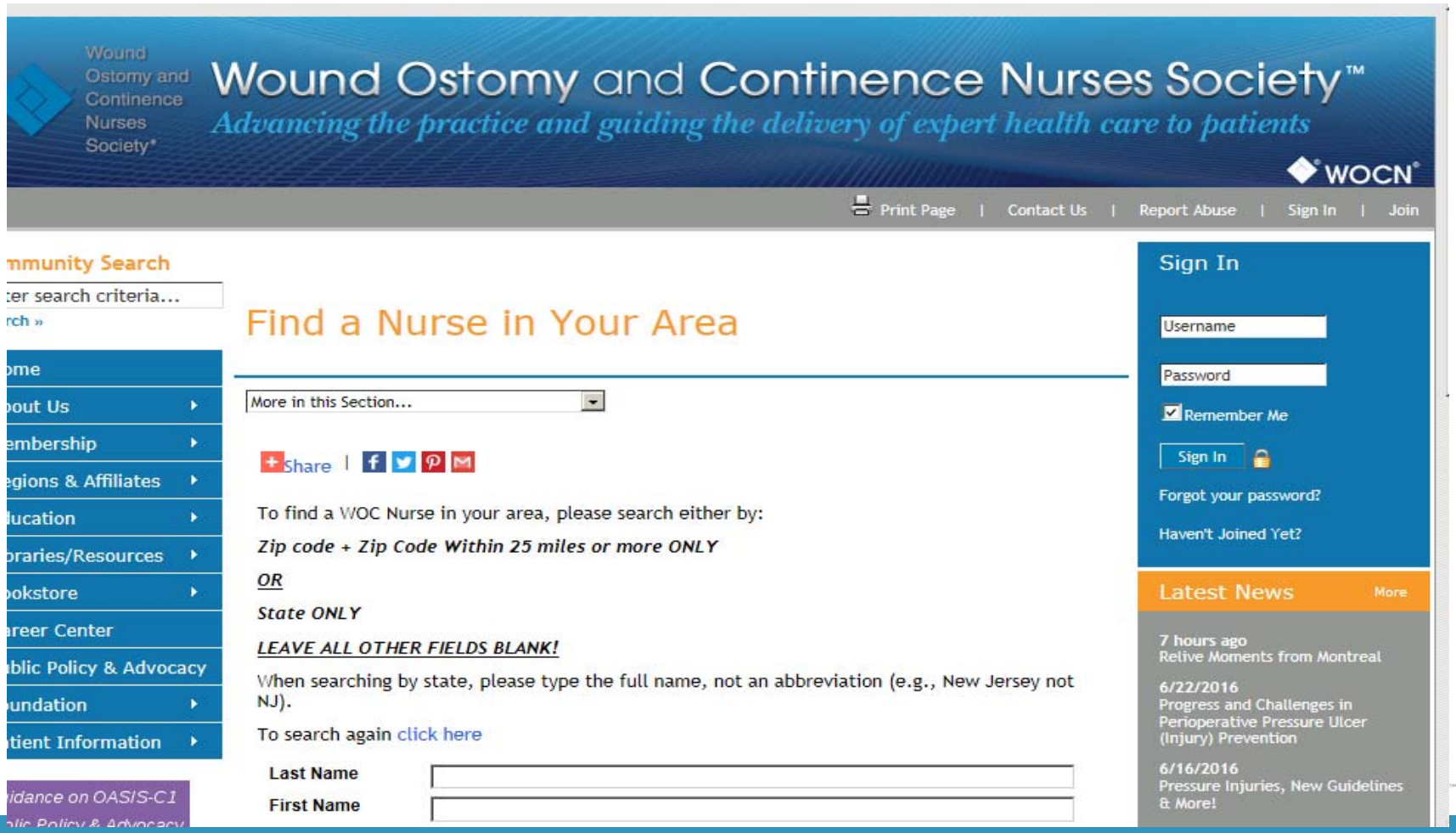
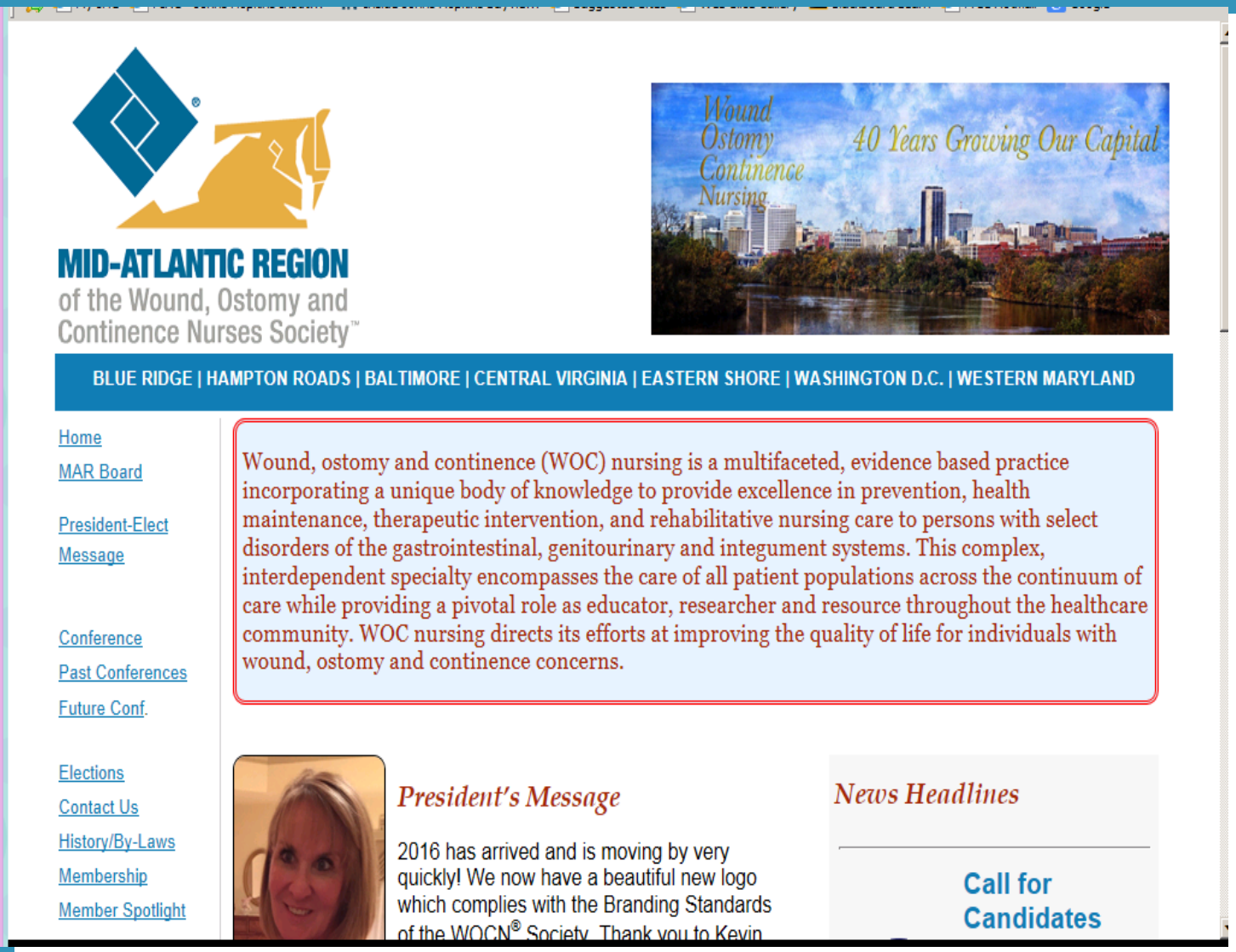
Team to promote skin safety and healing

- wound care nurse specialist
- podiatrist
- vascular surgeons
- plastic surgeons
- dermatology
- infectious Disease
- primary care
- dietitian
- social worker
- occupational/physical therapy/orthotics
- medical supplier
- care technicians
- extended community health care team
- **CAREGIVERS AND PATIENT.**

http://www.wocn.org/?page=Nurse_Referral





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WHEELCHAIR SEATING CLINICS IN MARYLAND

MARYLAND WOUND CENTERS 2016

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ONLINE LEARNING OPPORTUNITIES

- http://www.wocn.org/
- https://wtaprogram.com/
- www.Connect2Know.com
- *https://www.**medlinetrainingacademy**.com/*
- ConvaTec Learning Academy
- ***convatec.eol1.com/***
- http://www.coloplast.us/wound/wound-/coloplastacademy/
- http://www.hollisterwoundcare.com/connect-ed/algorithms.aspx

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Your Questions
&
Comments?


Thank You!